NC DMA Pharmacy Request for Prior Approval

Continuous Glucose Monitoring (CGM) System

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name: _____
3. Beneficiary ID #:_____ 4. Beneficiary Date of Birth:_____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information
   Name:_____ Phone #:_____ Ext. _____

System Information

8. Transmitter/ Sensor Name: Dexcom G5(Sensor only) ☐ Dexcom G6 ☐ FreeStyle Libre ☐
9 Quantity for Transmitter (G6) per 90 days _____(Max 1) 10. Quantity for Dexcom Sensor per 30 days ____(Max 3)
11. Quantity for Reader (Libre) _____(Max 1) 12. Quantity for Libre Sensors per 28 days ____(Max 2)
13. Length of therapy (in days) for Transmitter (G6 only) ☐ 90 ☐ 180 ☐ 365 Other: _____
14. Length of therapy (in days) for Sensor ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 Other: _____
15. Length of therapy (in days) for Reader (Libre) ☐ 365 Other: _____

For Dexcom G6 only:

16. Does the beneficiary have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6?
    ☐ Yes ☐ No (indicates need for Dexcom Receiver)

Clinical Information

For initial therapy, please answer questions 1-9, (max 6 months authorization):

1. Does the beneficiary have a diagnosis of insulin-dependent diabetes? Yes____ No____
2. Has the beneficiary been using a standard BGM (blood glucose monitor) and testing four (4) or more times daily or using a non-therapeutic CGM? Yes____ No____
3. Does the beneficiary require two (2) or more insulin injections daily? Yes____ No____
4. Does the beneficiary's insulin treatment regimen require frequent adjustment based on standard BGM or non-therapeutic CGM testing? Yes____ No____
5. Are the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? Yes____ No____
6. Has the beneficiary had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one through five (1-5) above have been met, within six months of the initial authorization? Yes____ No____
7. Does the beneficiary use an external insulin pump? Yes____ No____
8. For coverage of Dexcom G5 or G6; is the beneficiary age 2 years or older? Yes____ No____
9. For coverage of FreeStyle Libre; is the beneficiary age 18 years or older? Yes____ No____
10. For coverage of FreeStyle Libre; has the beneficiary tried using Dexcom G6? Yes____ No____ If no, is there a clinical reason Dexcom G6 could not be used? Yes____ No____ If yes, explain _____

For first reauthorization, please answer questions 11-13, (max 12-month authorization) DOCUMENTATION REQUIRED:

11. Has the beneficiary been using the CGM as prescribed? Yes____ No____
12. Has the beneficiary been able to improve glycemic control? Yes____ No____
13. Does the beneficiary continue to use as external insulin pump? Yes____ No____

For Subsequent reauthorizations please answer questions 14-17, (max 12-month authorization) DOCUMENTATION REQUIRED

14. Has the beneficiary had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three (3) months prior to submission of this reauthorization request? Yes____ No____
15. Has the beneficiary been using the CGM system as prescribed? Yes____ No____
16. Has the beneficiary been able to maintain or further improve glycemic control? Yes____ No____
17. Does the beneficiary continue to use an external insulin pump? Yes____ No____

Signature of Prescriber: _____ Date_____

(Prescriber Signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505